compare the medical benefits offered by health insurance and understand the extent of those medical benefits (or exceptions to those benefits).

(July 1, 1944, ch. 373, title XXVII, § 2715, as added and amended Pub. L. 111–148, title I, § 1001(5), title X, § 10101(b), Mar. 23, 2010, 124 Stat. 132, 884.)

AMENDMENTS

2010—Subsec. (a). Pub. L. 111–148, § 10101(b), substituted ''and providing to applicants, enrollees, and policyholders or certificate holders'' for ''and providing to enrollees''.

EFFECTIVE DATE

Section effective for plan years beginning on or after the date that is 6 months after Mar. 23, 2010, see section 1004 of Pub. L. 111–148, set out as a note under section 300gg–11 of this title.

§ 300gg–15a. Provision of additional information

A group health plan and a health insurance issuer offering group or individual health insurance coverage shall comply with the provisions of section 18031(e)(3) of this title, except that a plan or coverage that is not offered through an Exchange shall only be required to submit the information required to the Secretary and the State insurance commissioner, and make such information available to the public.

(July 1, 1944, ch. 373, title XXVII, § 2715A, as added Pub. L. 111–148, title X, § 10101(c), Mar. 23, 2010, 124 Stat. 884.)

§ 300gg–16. Prohibition on discrimination in favor of highly compensated individuals

(a) In general

A group health plan (other than a self-insured plan) shall satisfy the requirements of section 105(h)(2) of title 26 (relating to prohibition on discrimination in favor of highly compensated individuals).

(b) Rules and definitions

For purposes of this section—

(1) Certain rules to apply

Rules similar to the rules contained in paragraphs (3), (4), and (8) of section 105(h) of title 26 shall apply.

(2) Highly compensated individual

The term ''highly compensated individual'' has the meaning given such term by section 105(h)(5) of title 26.

(July 1, 1944, ch. 373, title XXVII, § 2716, as added and amended Pub. L. 111–148, title I, § 1001(5), title X, § 10101(d), Mar. 23, 2010, 124 Stat. 135, 884.)

AMENDMENTS

2010—Pub. L. 111–148, § 10101(d), amended section generally. Prior to amendment, text read as follows:

''(a) IN GENERAL.—The plan sponsor of a group health plan (other than a self-insured plan) may not establish rules relating to the health insurance coverage eligibility (including continued eligibility) of any full-time employee under the terms of the plan that are based on the total hourly or annual salary of the employee or otherwise establish eligibility rules that have the effect of discriminating in favor of higher wage employees.

''(b) LIMITATION.—Subsection (a) shall not be construed to prohibit a plan sponsor from establishing contribution requirements for enrollment in the plan or coverage that provide for the payment by employees with lower hourly or annual compensation of a lower dollar or percentage contribution than the payment required of similarly situated employees with a higher hourly or annual compensation.''

EFFECTIVE DATE

Section effective for plan years beginning on or after the date that is 6 months after Mar. 23, 2010, see section 1004 of Pub. L. 111–148, set out as a note under section 300gg–11 of this title.

§ 300gg–17. Ensuring the quality of care

(a) Quality reporting

(1) In general

Not later than 2 years after March 23, 2010, the Secretary, in consultation with experts in health care quality and stakeholders, shall develop reporting requirements for use by a group health plan, and a health insurance issuer offering group or individual health insurance coverage, with respect to plan or coverage benefits and health care provider reimbursement structures that—

(A) improve health outcomes through the implementation of activities such as quality reporting, effective case management, care coordination, chronic disease management, and medication and care compliance initiatives, including through the use of the medical homes model as defined for purposes of section 3602[1] of the Patient Protection and Affordable Care Act, for treatment or services under the plan or coverage;

(B) implement activities to prevent hospital readmissions through a comprehensive program for hospital discharge that includes patient-centered education and counseling, comprehensive discharge planning, and post discharge reinforcement by an appropriate health care professional;

(C) implement activities to improve patient safety and reduce medical errors through the appropriate use of best clinical practices, evidence based medicine, and health information technology under the plan or coverage; and

(D) implement wellness and health promotion activities.

(2) Reporting requirements

(A) In general

A group health plan and a health insurance issuer offering group or individual health insurance coverage shall annually submit to the Secretary, and to enrollees under the plan or coverage, a report on whether the benefits under the plan or coverage satisfy the elements described in subparagraphs (A) through (D) of paragraph (1).

(B) Timing of reports

A report under subparagraph (A) shall be made available to an enrollee under the plan or coverage during each open enrollment period.

(C) Availability of reports

The Secretary shall make reports submitted under subparagraph (A) available to the public through an Internet website.

[1] See References in Text note below.